FY 2013
Program Integrity Report

Fraud and Abuse Prevention and Detection
In Virginia Medicaid

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CYNTHIA B. JONES
DIRECTOR

APRIL 2014

SUITE 1300
600 EAST BROAD STREET
804/786- 7933
800/343-0634 (TDD)
www.dmas.virginia.gov

Dear Fellow Virginians:

I am pleased to present the Virginia Medicaid Program Integrity Annual Report for State Fiscal Year 2013. Virginia Medicaid program integrity efforts are not limited to a single division in DMAS, but involve the entire agency and coordination with a variety of outside partners. The report is a compilation of the fine work of the staff of the Department of Medical Assistance Services (DMAS) and our many partners.

The Program Integrity Division (PID) is entrusted with the responsibility of ensuring that the Virginia Medicaid is equipped to combat waste and abuse and also detect fraud. As DMAS stated in a presentation to the Medicaid Innovation Reform Committee on December 17, 2013, only a small percentage of Medicaid providers and recipients engage in various forms of fraud. However, as fraud and abuse affects everyone (the recipients of care, the taxpayers who pay for it, and the providers who provide quality care), it is important to have a Medicaid program that protects against improper payments. Each dollar lost to fraud is one less dollar available for someone in need of care.

During FY 2013, DMAS program integrity efforts identified $26.8 million in improper expenditures and prevented the payment of more than $220 million in potential improper expenditures. In addition, PID made efforts to expand fraud identification and prosecution, making 123 referrals of potential fraud, and continually improving coordination with the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU). DMAS Program Integrity and Health Care Services Divisions continue to work with DMAS' managed care partners to enhance program integrity within their organizations as well as within Virginia Medicaid. Lastly, the agency continues to develop new program integrity initiatives that will augment current practices through the use of analytical modeling.

The attached report provides information about DMAS program integrity efforts over the 2013 fiscal year to include statistical information, such as estimated savings and audit outcomes. I trust that you will find this report helpful in gaining insight into the Department's Program Integrity activities.

Sincerely,

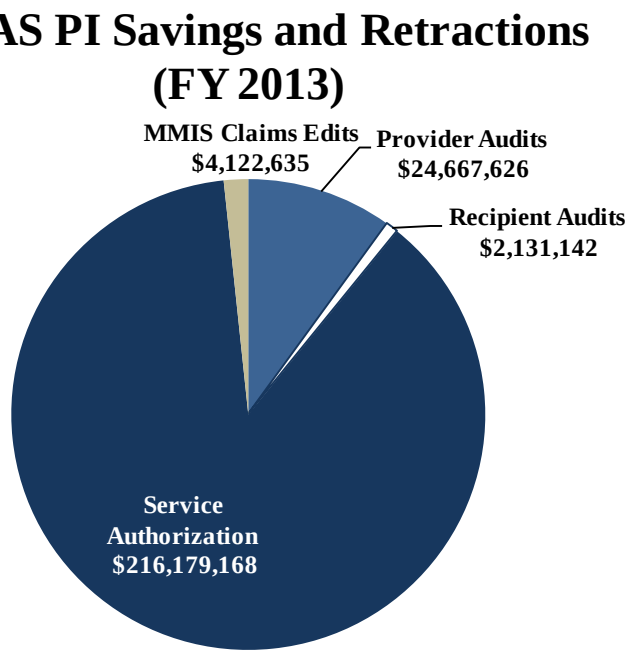
Cindi Jones, Director
Department of Medical Assistance Services

Table of Contents

Executive Summary

Program Integrity (PI) is the collective term given to activities conducted by the Department of Medical Assistance Services (DMAS) to ensure taxpayers' dollars are spent effectively and appropriately. The mission of the Program Integrity Division (PID) is to protect the Medicaid program from external abuse and fraudulent activities, recover inappropriate Medicaid payments, as well as support the integrity efforts of the various Medicaid programs through oversight and technical assistance. The activities of PID are supported by the PI efforts of other DMAS divisions, as well as the efforts of contractors and partner agencies to identify fraud and abuse.

During FY 2013, Program Integrity Division activities uncovered and/or prevented $243 million in improper expenditures in the Virginia Medicaid program. In addition to efforts by PID, prepayment edits in DMAS' claims processing system saved over $4 million by blocking or reducing reimbursement on improperly-filed claims.



As seen in the chart, a large portion of program integrity savings in FY 2013 came from cost avoidance due to the service authorization process, which denies medically unnecessary service requests. While prevention is preferable, not all improper payments can be detected before payment occurs. For that reason, DMAS conducts a variety of audit activities to identify misspent funds. As a result, $26.8 million in recoveries is attributable to audits of providers and recipients conducted by Program Integrity Division staff and contractors.

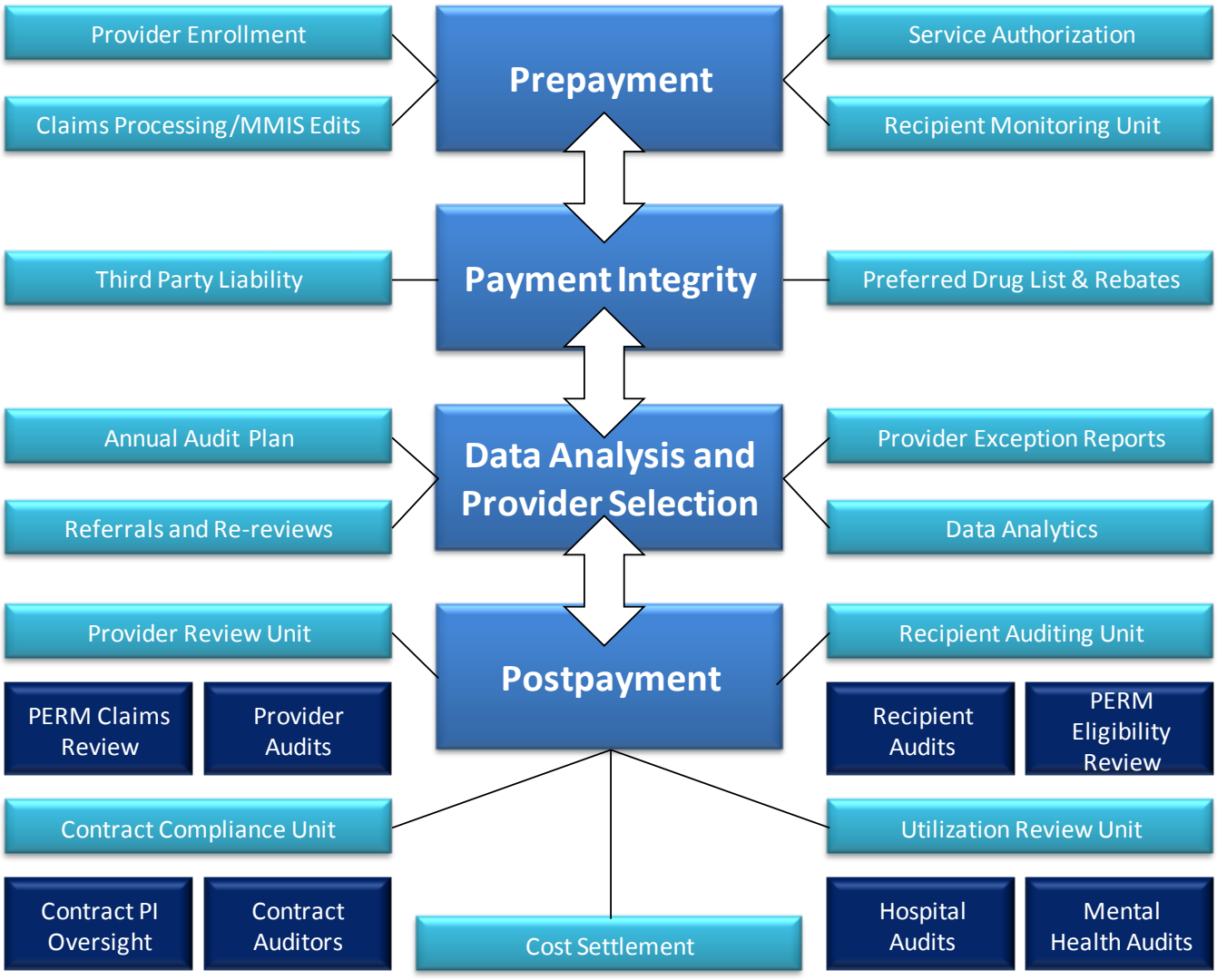
PID's program integrity activities are further supported by the integrity-related efforts of the Department's eight major national program integrity contracts, new behavioral health and incontinence contractors, transportation broker, and the integrity programs of each of the seven managed care organization.

Virginia has received national recognition for its efforts in Medicaid program integrity. The director of the PI Division serves on the Center for Medicare and Medicaid Services (CMS) PI Technical Advisory Group (TAG), which is fundamental in developing and evaluating national PI efforts and led the national PID and MCFU collaborative effort. PID staff members present for various seminars and national conferences including training sessions at the Medicaid Integrity Institute (MII), a joint program of the Department of Justice (DOJ) and the Centers for Medicare and Medicaid Services (CMS.)

Executive Summary

DMAS' PI efforts are summarized in four major areas:

- **Prepayment** processes to enhance cost avoidance by preventing improper expenditures on services that are not medically necessary (Service Authorization), and providers who are not eligible to participate in Medicaid (Provider Exclusion). Prepayment programs also ensure claims are paid according to DMAS policy (Claims Processing) and control over-utilization of Medicaid services by recipients (Recipient Monitoring Unit.)
- **Payment Integrity** processes that ensure DMAS pay only its share of recipient medical expenditures (Third-Party Liability) and that DMAS receives all of its pharmacy rebates.
- **Data Analysis and Provider Selection** processes that identify potential risk areas to help inform decisions on where to target program integrity resources.
- **Post-payment** processes that identify instances of improper provider billings and improper recipient enrollment through investigation of referrals and audits of paid claims, some of which are forwarded on for fraud prosecution.



Preventing Improper Medical Expenditures

Preventing improper claims from being paid is always preferable to identifying improper payments after they have been paid and provides an additional deterrent to providers who knowingly submit inaccurate claims. Three major components of prepayment program integrity are the MMIS claims processing system, provider network management and the service authorization process. MMIS is an automated system that ensures certain rules are met before a claim is processed for payment to a provider. For some services, providers are required to obtain service authorization, an evaluation of whether the service is medically necessary, before a claim can be paid. Together, these processes prevented over $220 million in improper expenditures during FY 2013.

MMIS Claims Processing Edits

DMAS always has subjected claims to rigorous prepayment scrutiny through its automated claims processing and review system called the Medicaid Management Information System (MMIS). Currently there are over 1,550 edits in the Virginia MMIS. These edits are rules that must be passed before claims are adjudicated for payment. For example, these edits reject duplicate claims and claims for services or service levels that are not authorized under Medicaid policy. One particular set of prepayment edits utilized by DMAS is the McKesson ClaimCheck software, which cost-avoided $1.98 million in FY 2013. In June 2013, DMAS implemented the CMS-mandated prepayment National Correct Coding Initiatives (NCCI) edits to improve the prepayment claims review process. The NCCI edits saved $174,600 in June 2013 alone.

Provider Network Management

Provider enrollment processes ensure the integrity of the provider network by reviewing credentials of individuals applying to enroll as Virginia Medicaid providers. In addition, enrolled providers are routinely reviewed and unqualified or barred providers are terminated from the program. In the first quarter of 2014, DMAS will become the first state agency in the region to implement enhanced provider screening requirements under the Affordable Care Act (ACA.) Implementation involved collecting large amounts of provider information in digital format to allow DMAS to regularly screen both service providers and business owners against a variety of federal databases of banned and/or suspect providers.

All providers must also undergo additional automated screening, and provider types labeled moderate- or high-risk, such as Durable Medical Equipment and Home Health, also must undergo unannounced site visits. DMAS estimates that there are currently about 5,700 providers in these moderate and high-risk categories enrolled in the Virginia Medicaid system, but will leverage CMS' screening on about 80% of those providers, since they have already been subject to this review as Medicare providers.

These additional provider enrollment measures will help to prevent improper payments by providing more complete and up-to-date information on providers as well as greater scrutiny on the enrollment of riskier providers. They may also provide new opportunities for auditors to identify connections between fraudulent or problematic providers through shared ownership or management.

Preventing Improper Medical Expenditures

Service Authorization

DMAS requires providers to obtain prior authorization of the medical necessity of certain services (referred to as service authorization) before a claim can be paid through MMIS. DMAS contracts with Keystone Peer Review Organization (KePRO,) which provides telephone and internet access for providers to request authorization. KePRO medical staff review the information submitted by providers and determine if the service is medically necessary under DMAS policy. As seen in the table below, service authorization avoided costs of over $216 million in FY 2013.

Type of Review	FY 2012 Denied Units/Days	FY 2012 Program Savings	FY 2013 Denied Units/Days	FY 2013 Program Savings
Inpatient	10,222	$5,289,375	22,149	$23,706,680
Outpatient	2,840,123	$176,378,298	2,434,556	$181,254,105
Waivers/Other Services	824,331	$12,986,506	729,636	$11,218,384
Total	**3,674,676**	**$194,654,150**	**3,186,341**	**$216,179,168**

The total number of services approved or denied decreased 5.4% in FY 2013 compared to FY 2012. Reviews of many traditional services, such as inpatient and imaging, decreased due to the increase in recipients covered under managed care, while the new contract in November 2012 added services such as EPSDT Personal/Attendant Care and Specialized Care/Long Stay Hospital. There was an 11% increase in estimated cost savings during FY 2013 as compared to FY 2012, largely due to denials for newly-added services.

In addition to cost avoidance from denied service requests, the service authorization process also creates a "sentinel effect" as providers are deterred from submitting requests for medically unnecessary services. In fact, this may explain the reduction in requests for most services that were subject to service authorization in prior years. Service authorization also helps to facilitate fraud prosecutions by requiring additional documentation which can be compared to the medical record to identify discrepancies.

Incontinence Supply Procurement

In order to more effectively manage the purchase of incontinence supplies (diapers, liners, etc.), in FY 2013, DMAS sought to move all of these supplies to a sole-source vendor. Through a competitive bidding process, DMAS awarded a sole contract for the provision of incontinence supplies for all Medicaid fee-for-service members in the Commonwealth effective January 1, 2014. All Medicaid members will order and receive their supplies through this vendor, but the service authorization contractor still will review requests and verify medical necessity before these requests can be filled. This centralization will ensure that utilization of these supplies is appropriate, and that purchasing is done in a cost-effective manner.

Ensuring Accurate Recipient Eligibility

DMAS conducts a wide variety of activities to ensure the accuracy and integrity of the Virginia Medicaid recipient enrollment process. Audits are conducted to identify recipients who do not meet eligibility requirements, as well as to uncover improperly paid provider claims. DMAS also collaborates with the Virginia Department of Social Services, the State police, and a new eligibility contrator to address recipient fraud and abuse, as well as enrollment accuaracy.

Recipient Audit Unit

The Recipient Audit Unit (RAU) is responsible for the investigation of allegations of acts of fraud or abuse committed by recipients of the Medicaid, Family Access to Medical Insurance Security (FAMIS), and State & Local Hospital (SLH) programs. The investigations may result in the identification of misspent funds, administrative recoveries from recipients, or criminal prosecution. These allegations typically involve recipient eligibility issues such as: deceit in application; illegal use/sharing of a Medicaid card; uncompensated transfer of property; excess resources or income; or fraudulent household composition. The unit also investigates drug diversion and performs joint investigations with various law enforcement entities (the Virginia State Police, the FBI, etc.), as well as the Social Security Administration, and other federal/state agencies.

In FY 2013, the RAU received 1,992 referrals from various sources, such as citizens, providers, and local Departments of Social Services. RAU investigated 1,579 referrals over that time period and uncovered a total of $5,085,456 in improper payments. Of that, $2,131,142 was submitted for administrative recovery and 34 individuals with $457,024 in overpayments were forwarded on for criminal prosecution. During FY 2013, 32 individuals were convicted of fraudulently obtaining benefits and ordered to pay $187,723 in restitution. These recipients also are banned from the Medicaid program for one year (the maximum time allowed under federal law,) and can be subject to jail time as well.

Payment Error Rate Measurement (PERM) Eligibility Review

The federal government conducts the PERM review every three years in each state to measure improper payments in state Medicaid program. The findings of the PERM project are used to determine how Virginia measures up on a national level in the area of payment accuracy. Virginia's last review of recipient eligibility determination occurred in federal fiscal year 2009 and found that local departments of social services had made errors in approximately 17 percent of cases. The vast majority (2/3) of these "errors" were undetermined cases, where information needed to establish eligibility could not be obtained.

The PERM review for the FFY 2012 cycle began in August 2011. DMAS engaged a contractor to facilitate these reviews with the main goal of minimizing the number of "undetermined" cases and lowering substantially Virginia's final PERM error rate. DMAS and the contractor worked closely with the Virginia Department of Social Services to ensure that all efforts were made to obtain necessary eligibility documentation. CMS has confirmed that Virginia's PERM Medicaid payment error rate is 0.47%. These error rates are determined by extrapolating the errors in the PERM sample through a statistical model developed by CMS.

Auditing Improper Provider Payments

The Program Integrity Division (PID) and its contractors focus extensively on providers, particularly audits of paid claims to Medicaid FFS providers. These audits generally examine a selection of claims filed during prior fiscal years to ensure that the claims were filed in accordance with DMAS and Medicaid policy. In most cases, these audits involve examining medical records to ensure that the record exists, supports the claim as billed, and is completed in accordance with DMAS policies. In addition, some audits may examine the credentials of the servicing provider to ensure they are qualified to provide the service that was billed. **During FY 2013 provider audit activities, DMAS and its contractors identified over $24.6 million in overpayments to Medicaid providers.** Contractors play an integral role in provider auditing, supplementing staff audits and providing knowledge and expertise in identifying audit targets and conducting reviews. In FY 2013, DMAS issued RFPs and awarded new contracts for three of its four audit contracts.

	FY 2012 Total Audits	FY 2012 Overpayments	FY 2013 Total Audits	FY 2013 Overpayments
DMAS - Provider Review Unit	156	$1,071,533	119	$1,567,571
DMAS - Mental Health	55	$2,962,497	30	$1,747,356
DMAS - Hospital	95	$1,393,622	80	$1,357,800
PID Audit Total	306	$5,427,652	229	$4,672,727
Xerox - Pharmacy & DME	80	$1,688,343	79	$1,817,101
Health Management Systems - Hospital DRG	87	$5,867,252	90	$5,551,574
Health Management Systems - Mental Health	125	$3,724,883	70	$2,197,265
Myers & Stauffer - Physicians & Waiver Services	309	$8,645,195	320	$10,428,959
Contractor Audit Total	601	$19,925,673	559	$19,994,899
Total, PID and Contractor Audits	907	$25,353,325	788	$24,667,626

Payment Error Rate Measurement (PERM) Claims Review

A federal review of the accuracy of claims payment was conducted during FY 2013 on a sample of claims filed for the months of October 2011 through September 2012. Two distinct reviews were conducted: a data processing review that looked at whether claims were paid correctly based on information captured in the claims payment system; and a medical record review, which examined provider medical records to determine whether documentation is accurate and complete. The data processing (DP) review identifies errors such as pricing errors and duplicate claims for a single service. The medical record review identifies errors such as inaccurate diagnosis coding and insufficient documentation for billed services.

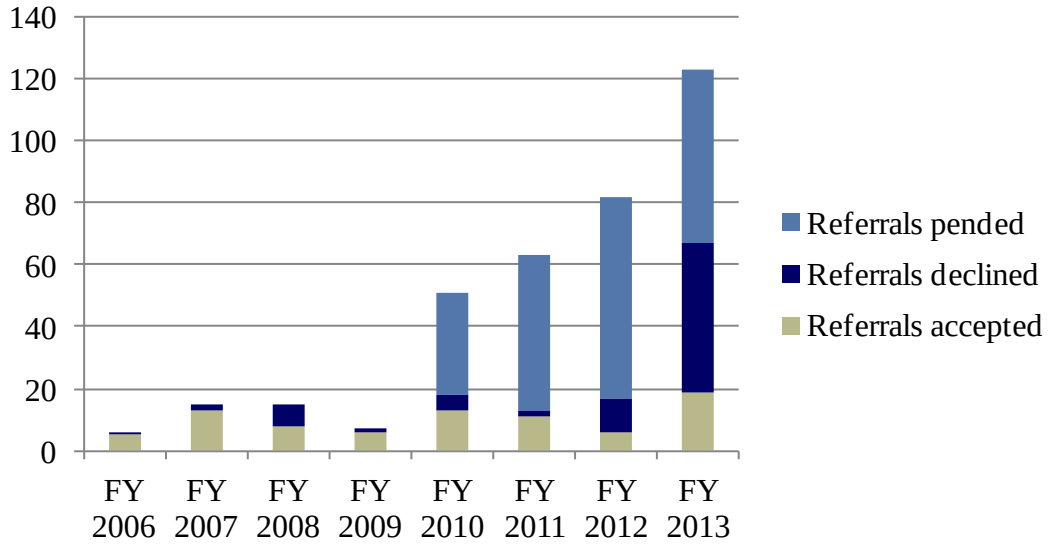
CMS issued final error rates for Virginia on December 20, 2013. The Medicaid FFS estimated PERM error rate is 2.2 percent, which was below the national error rate of 3.4 percent for this PERM cycle. It is important to note that this is an error rate for claims that had yet to be subject to any post-payment auditing conducted by DMAS or its contractors.

Working Together to Fight Medicaid Fraud

In addition to identifying improper payments for collection, audits conducted by DMAS and its contractors may uncover evidence of potential fraud. Medicaid fraud is a criminal act that occurs when a Medicaid provider or recipient intentionally misrepresents themselves in order to receive an unauthorized benefit. Pursuant to federal law, Virginia's Medicaid Fraud Control Unit (MFCU) was established as a division of the Office of the Attorney General in 1982 and works closely with DMAS to investigate and prosecute suspected cases of Medicaid provider fraud. In addition to establishing restitution for past fraudulent activities, fraud convictions play an important role in program integrity more broadly, as convicted providers are banned from Medicaid participation for life.

DMAS refers potential cases of fraud uncovered through DMAS PI activities to the MFCU, provides program knowledge to aid in investigations, and testifies in cases. DMAS has an exceptional working relationship with the MFCU that continues to improve through constant communication and collaboration, including monthly meetings between staff of the two agencies and the MFCU's participation in quarterly program integrity collaborative meetings with DMAS and its managed care partners. In FY 2013, MFCU obtained convictions of 23 health care providers. **Those cases resulted in a total of $5,806,449 in court-ordered fines, penalties, and restitution to the Virginia Medicaid program.** In addition, each of the 23 health care providers was barred for life from participating in the Medicaid program. In addition to working on criminal fraud cases, DMAS also aids MFCU civil prosecutions by reviewing records and testifying in national qui tam cases against pharmaceutical manufacturers. These cases result in some of the largest MFCU recoveries, like the $1.5 billion fraud settlement against Abbott Laboratories in October of 2012.

As seen in the graph below, DMAS referrals to MFCU increased substantially beginning in FY 2010, due to an increased capacity to investigate and identify cases of fraud. In FY 2013, DMAS made 123 referrals of suspected fraud to the MFCU. MFCU accepted 19 of these referrals, a substantial increase from prior years. In addition, MFCU accepted an additional seven cases from those that were pended in FY 2011 and FY 2012. MFCU's addition of 25 investigators, attorneys, and support staff to facilitate criminal and civil investigations in FY 2011 has resulted in this ability to investigate a larger number of cases and potentially recover millions of additional dollars in fraudulently obtained Medicaid funds.



Enhancing PI Through Managed Care Collaboration

The majority of Medicaid recipients are covered by managed care organizations (MCOs) that receive a contracted monthly rate for each enrolled member, and each MCO is responsible for paying providers directly for the medical services incurred by its members. The MCOs are required to have policies and procedures in place to prevent, detect and investigate allegations of fraud, waste and abuse. **In FY 2013, MCO program integrity activities avoided or recovered more than $417 million, including $396 million in prevented payments for things such as non-covered services, ineligible recipients, and improper claims.**

PID works closely with the Health Care Services Division (HCSD) on any changes or clarifications to the MCO contract that are needed to ensure adequate MCO program integrity. Recent changes to the contract have improved the accuracy and consistency of MCO reports on PI outcomes and clarified the process for reporting cases of potential fraud. Each year, PID and HCSD conduct a joint audit of each MCO's compliance with the program integrity requirements under the MCO contract. The FY 2013 Program Integrity Compliance Audit (PICA) took a more in-depth examination of the content of reports, annual audit plans, etc., to ensure that policies were being followed and that reporting appears accurate and complete. As a result of this review, each of the MCOs made adjustments to their audit plans that will improve the ability of DMAS staff to evaluate each plan's program integrity activities and understand how those plans evolve from year to year. As a testament to the strong working relationship between managed care policy and program integrity at DMAS, PID and HCSD were asked to make a presentation on the Virginia Medicaid program to the National Advisory Conference Medicaid Integrity Institute in September 2013.

Since FY 2011, the unit has held quarterly Managed Care Program Integrity Collaborative meetings that provide a venue where program integrity staff from the MCOs and DMAS can share information about their PI functions and identify opportunities to improve overall Medicaid program integrity. This collaborative also has provided the opportunity for a more comprehensive approach to fraud and abuse prevention across all Virginia Medicaid payers. In FY 2013, representatives from the MFCU began to regularly attend these meetings, facilitating an open discussion on developing fraud cases and contributing to a better, more coordinated relationship between MCOs and the MFCU. The collaborative has been identified as a national best practice and DMAS staff members have presented the model to Medicaid staff from other states at a variety of national conferences.

FY 2013 MCO PI Collaborative Meetings
September 27th, 2012
January 10th, 2013
March 28th, 2013
June 20th, 2013

During FY 2013, DMAS was in the process of bringing a wide variety of new services and types of members under a managed-care system. One effort involved covering members who are eligible for both Medicaid and Medicare ("Dual Eligibles") through managed care instead of fee-for-service. Another major effort was the development of managed care structure to pay for outpatient behavioral health services, which were historically "carved-out" of the services provided by MCOs and paid for directly by DMAS. During the development of contracts related to these efforts, staff from PID's Contract Compliance Unit provided guidance on contract language to ensure adequate program integrity activities are conducted.

Working with Home and Community-Based Service Providers

After successful meetings in the summers of 2011 and 2012, the 2013-14 Appropriations Act once again directed DMAS to convene representatives of Home and Community-Based Services (HCBS) providers to continue improvements in the audit process and procedures for HCBS utilization and review audits. HCBS are provided to individuals enrolled in Medicaid who meet criteria for admission to a hospital, nursing facility (NF) or Intermediate Care Facility but choose to receive services in a less restrictive and less costly community setting. Services may include personal care, respite care, adult day health care, and a range of other support services.

This advisory committee provided an opportunity for the HCBS provider community to share their concerns about the DMAS audit process with DMAS staff and contractors. DMAS has worked to understand these concerns and has made several changes to the audit process as a result, including working to ensure that audits include large and small providers. In addition, DMAS was directed to report on this meeting and include documentation of the past year's HCBS audits and appeals, a summary of which is provided below:

FY 2013 HCBS Workgroup Members
Virginia Association for Home Care and Hospice
Virginia Association of Personal Care Providers
Virginia Association of Community Services Boards
Virginia Network of Private Providers, Inc
Virginia Association of Centers for Independent Living
Virginia Association of Community Rehabilitation Programs
Virginia Adult Day Health Services Association
Virginia Association for Hospices & Palliative Care

DMAS and its contractor conducted a total of 298 audits of HCBS providers during FY 2011 and FY 2012. Audited providers had total billings of more than $162 million for HCBS services during the audited period, of which the audits examined about $37 million.

Fiscal Year Audit Conducted	Total Audits Conducted	Amount Paid to Audited Providers	Total Dollars Audited	Total Dollars in Error	Total Dollars Appealed	Total reduction in overpayments (Appeals)
FY 2011	139	$ 49,903,922	$ 19,148,381	$ 6,203,338	$2,807,362	$667,940
FY 2012	159	$ 17,648,956	$ 17,851,067	$ 5,431,906	$4,139,916	$811,682
Total	298	$ 67,552,878	$ 36,999,449	$ 11,635,244	$6,947,278	$1,479,622

In the past, stakeholders expressed some concern that the DMAS provider selection process results in larger providers being targeted while smaller providers are not audited. An analysis of the audits conducted by DMAS and its contractor in FY 2011 and FY 2012 showed that providers of all sizes were audited and that the majority of audits (64%) were conducted on providers with $100,000 to $1 million in claims, which is the category in which the majority of providers fall. In addition, audits of providers with less than $50,000 in claims more than doubled from 22 to 49 from FY 2011 to FY 2012, while audits of providers with greater than $1 million in claims fell from 29 to 15. More detailed information on audits and appeals as well as the activities of the workgroup can be found in DMAS' *Report on Audits of Home and Community-Based Services.*

Contractors Identifying Additional Recoveries

Recovery Audit Contractor

As a result of the Affordable Care Act becoming federal law in 2010, States are required to establish programs to utilize Recovery Audit Contractors (RACs) to audit payments to Medicaid providers. RACs are paid on a contingency fee basis, receiving a percentage of the improper overpayments and underpayments they identify and collect from providers. Pursuant to language in Virginia's FY 2011-2012 budget bill authorizing DMAS to employ RAC auditors, DMAS issued an RFP in March 2012 for proposals from qualified and innovative health care auditing firms to provide RAC services for Virginia's Medicaid program. The contract was awarded to Health Management Systems with an effective date of July 10, 2012. The cost to the State is minimal for this program, as the RAC's contingency fees will come out of recovered overpayments, and the Federal Government will cover 50 percent of any administrative costs.

Upon the initiation of the RAC contract in September 2012, HMS evaluated and analyzed DMAS historic data on processed claims to identify potential areas of audit. After completion of the review in November 2012, HMS proposed for DMAS approval a total of twenty-four potential audits to conduct during the contract year. In order to ensure that audits could be completed in short order, HMS focused on audits that would not require desk or on-site reviews. Instead, these audit proposals generally focused on claims that appeared to have been paid improperly, based on the information contained in the claim file.

As of June 30, 2013, HMS has moved forward on three DMAS-approved audit proposals with total identified overpayments of more than $1 million. DMAS has provisionally approved two additional audit proposals, which are currently being reviewed by DMAS to ensure that the claims have not already been subject to a previous DMAS audit. Two other audit proposals were deemed not viable due to a limited number of potentially improper claims. The remaining 17 proposals are in various stages of development and refinement.

Medicaid Fraud and Abuse Detection System

DMAS is committed to the continuous improvement of its PI tools to contain costs, reduce inaccurate or unauthorized claims and reimbursement, and better detect fraud and abuse. As a result, DMAS issued an RFP in late FY 2012 for development of a Medicaid Fraud and Abuse Detection (MFAD) system that will enhance efforts to further identify potential fraud, waste, and abuse (FWA) target areas. The contract was awarded and the MFAD project began in July 2013. The system has created a series of tests that identify possible FWA behavior based on known patterns, issues, and scenarios as well as using statistical models to identify anomalies, outliers and trends. During the first year of the contract, the system identified approximately $44M in potential recoveries for DMAS. During FY 2014, the RAC will be used to evaluate these potential recoveries and determine what of the $44M is actually recoverable. In addition, the RAC will be used to issue recovery letters to providers for the identified overpayments.

Conclusion

The combined program integrity efforts of DMAS identified and/or prevented $246.8 million in improper expenditures in the Virginia Medicaid program in FY 2013. The vast majority of these dollars ($220 million) were savings from prepayment activities such as service authorization and MMIS claims processing edits, which stop improper payments before they are made. DMAS will look to prevent even greater amounts of unnecessary expenditure in the future through enhanced provider screening and the implementation of prepayment analytics through its newly-created fraud and abuse detection system.

In addition, audits of providers and recipients uncovered $26.8 million in improper payments during FY 2013. Contract auditors play a large role in the DMAS PI process and in FY 2013; DMAS issued RFPs and awarded new contracts for three of its four audit contracts. This process allowed DMAS to identify opportunities to enhance these contracts through new areas of focus and deliverables.

DMAS also has engaged a Recovery Audit Contactor (RAC) which is currently auditing provider claims and being reimbursed on a contingency-fee basis for the recoveries they identify. DMAS also has enhanced its risk analysis and data mining capabilities through development of a Medicaid Fraud and Abuse Detection system, which identified $44 million in potential improper payments that will be investigated and recovered under the RAC.

DMAS has fostered a collaborative approach with its program integrity partners through monthly meetings with the Medicaid Fraud Control Unit as well as the quarterly Managed Care Program Integrity Collaborative. The collaborative has become a national model and has already helped to create an open and cooperative approach to PI in Virginia Medicaid across all payers. DMAS worked vigilantly to stamp out fraud, resulting in criminal convictions of 32 Medicaid recipients and 23 Medicaid providers and over $5 million in court-ordered fines, penalties, and restitution to the Virginia Medicaid program.

As we move forward, DMAS will continue to find ways to further ensure the integrity of the Medicaid program, and will remain vigilant in identifying and preventing fraud, waste and abuse.